

# Approaches to control sexually transmitted diseases in Haiti, 1992–95

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*Despite major obstacles, activities to control sexually transmitted diseases (STDs) were initiated in Haiti in 1992 in collaboration with local nongovernmental organizations. The approaches included review of available local data, assessment of STD case management practices and constraints, and development of specific STD control activities at the primary health care level, such as systematic screening of all pregnant women for syphilis and improved comprehensive syndrome-based STD case management. The activities included conduct of local studies, presentation and dissemination of results to key audiences, training of health care providers, improvement of local capacities, and consensus-building on implementation of STD control approaches.*

*STD awareness and case management improved considerably; for example, 69% of the clinicians interviewed reported correct STD treatments in the north-eastern primary health care centres in 1995, compared with <10% in 1992. At the end of the project, national STD case management guidelines were developed by consensus between the various organizations and the Ministry of Health. Lessons learned included the importance of local data generation and of communication and collaboration with various institutions for consensus-building, the need for continued training, and field supervision to ensure behaviour change among STD care providers. A national STD control programme should be implemented as soon as possible in both the public and private sector. External funding will remain critical to control this important public health problem in Haiti.*

## Introduction

In 1991, following a competitive selection procedure, the U.S. Agency for International Development (USAID) awarded funds to Family Health International (FHI), based in North Carolina, to help designated developing countries with the control of human immunodeficiency virus (HIV) infections. The AIDS Control and Prevention (AIDSCAP) project and strategy for HIV control comprised three major components: communication to promote behaviour change, encouragement of condom

use, and control of bacterial sexually transmitted diseases (STDs). Haiti was one of the 15 countries where this AIDSCAP strategy was implemented.

In mid-1992, Haiti was suffering from major political and socioeconomic problems when the initial activities to control STDs were started. The first democratically elected president in Haiti's history had been ousted by a military junta and political crimes and human rights abuses were rampant. Over the next 2 years political and economic pressures were placed on the military regime to restore democracy. The economic hardships long experienced by the vast majority of Haiti's population were exacerbated. Although most internationally sponsored development activities were halted, HIV control activities were allowed as part of humanitarian assistance; however, direct collaboration with the de facto government was not permitted until the restoration of democracy in October 1994.

The absence of a national STD control programme was one striking feature of the Haitian situation in 1992. Furthermore, almost no data were available on the magnitude and scope of STDs in Haiti, and no organized information on provision of STD care in the public or private sector was available. The STD clinic at the National Reference Laboratory, an institution well known for HIV/AIDS (acquired immunodeficiency syndrome) re-

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search under the name Cornell-GHESKIO, reported that on average only one to two patients presented per day for STD care.<sup>a</sup> Local health professionals reported that patients preferred self-medication, particularly for STDs, and ampicillin and tetracycline could easily be bought over the counter. The scene was further complicated by institutional rivalries and limited STD awareness or interest among the health care providers.

Despite these numerous obstacles, activities were planned for STD control — baseline information to be gathered, STD control interventions to be initiated, and activities to be monitored — with the hope that eventually a national STD control programme would be developed. This article describes the STD control approaches and interventions that we initiated under difficult circumstances and presents the lessons learned that might be applicable outside Haiti.

## Methods

Various nongovernmental organizations (NGOs) in Haiti were contacted and asked to participate in the study. A search for available data regarding STDs was started and data were reviewed. STD case management practices and constraints were evaluated in five nongovernmental primary health care centres through provider interviews, observation, and reviews of laboratory logbooks and patients' files. The findings were summarized in a report and presented to an ad hoc advisory committee.

Subsequently, a group of pregnant women was evaluated for a proxy assessment of population-based STD baseline data. Primary health care providers were trained in STD case management. Major local NGOs developed and implemented STD control strategies. The quality of STD case management in the participating NGOs was evaluated using a questionnaire developed by the WHO Global Programme on AIDS (WHO/GPA) (1), but focusing on those questions relevant to the local context.

Efforts to promote consensus-building on implementation of STD control approaches comprised communication and collaboration with different organizations involved or interested in STD control, such as local NGOs and PAHO/WHO. Funding for STD control activities was provided by USAID through AIDSCAP and by PAHO/WHO. The Uni-

versity of North Carolina and AIDSCAP provided technical assistance.

## Results

### *In 1992*

One large NGO, the Centres pour le Développement et la Santé (CDS), which provides care to more than 500 000 destitute, primarily urban Haitians, was interested in developing an STD control strategy. A team of two U.S.-based and two local professionals evaluated existing STD case management practices in five primary health care (PHC) centres run by CDS in Cité Soleil, Gonaïves, and Cap Haitien. The site visits revealed several serious deficiencies. For example, 10 (90.9%) of the 11 doctors interviewed reported treating urethral discharge with penicillin or ampicillin, while at the Cornell-GHESKIO STD clinic about 60% of the isolated gonococcal strains produced penicillinase (personal communication, B. Liautaud, 1992). The doctors interpreted the presence of extracellular Gram-negative diplococci in vaginal smears as proof of a gonococcal infection. Treatment for chlamydial infections was ignored. Case management of genital ulcers varied from use of ineffective topical disinfectants to penicillin injections. The assessment further showed that the sexual partners of STD patients were seldom treated, and that pregnant women were rarely screened for syphilis.<sup>b</sup>

These findings were discussed with an ad hoc advisory group of local authorities from NGOs (some of whom also worked in the public sector), international donors, and one traditional healer. A strategy was proposed to CDS, which consisted of training of PHC doctors in comprehensive STD case management, including effective treatment of the patient and his/her sexual partners, as well as patient and partner education about the importance of compliance with therapy, and the means of preventing future infections. Syndromic rather than etiological STD treatment approaches were recommended because of limited laboratory diagnostic capabilities. Although no local supporting data were available, treatment regimens covering both gonococcal and chlamydial infections for urethral discharge and cervical infections were proposed. This proposal was accepted by the CDS authorities but not by local

<sup>a</sup> Liautaud B et al. Preliminary data on STDs in Haiti. Paper presented at: *Eighth International Conference on AIDS/III STD World Congress*, 19–24 July 1992, Amsterdam, Netherlands. Abstract No. PoC 4302.

<sup>b</sup> Behets F et al. STD control in a large, slum-based Haitian health institution: confronting the obstacles and designing a strategy. Paper presented at: *Ninth International Conference on AIDS*, 6–11 June 1993, Berlin, Germany. Abstract No. PO-C22-3148.

members of the group (e.g. from Cornell–GHESKIO). In general, most of the discussions and disagreements concerned the content of the specific algorithms for syndromic STD treatment. As a result, the CDS-developed algorithms differed from those used by Cornell–GHESKIO. Screening of all pregnant women for serological evidence of syphilis was considered a strategic priority. Recommendations were made for quality assurance and for reporting by syndrome rather than by unreliable diagnosis. Community-based as well as clinic-based education was suggested to explain the importance of seeking care in the clinics rather than relying on self-treatment and to promote STD prevention. The drug lists at the CDS clinics were to be updated to include drugs effective against gonococcal infections.

### **In 1993**

Following the two-week, U.S.-based training of one doctor and one laboratory technician, 1001 women attending two CDS antenatal clinics located in Cité Soleil were evaluated with on-site technical assistance, as a proxy assessment of population-based STD baseline information. The results of this baseline study have been published (2). In summary, 11% of the women were found to be syphilis seroreactive, 34% had trichomoniasis, 10% had chlamydial cervical infection, 4% had gonococcal cervical infection, and 47% had at least one STD. A partner-referral pilot trial showed that 30% of the male partners of pregnant women with an STD presented at the clinic for treatment as a result of referral by the woman; another 11.5% presented for treatment after referral by a community health worker. No adverse psychosocial reactions were reported and overall the participants appreciated the initiative (3).<sup>c</sup>

The Cité Soleil study results were shared locally with professionals involved or interested in STD control and were used to raise awareness and build consensus for specific approaches. For example, the data showed the high prevalence of chlamydial infections, thereby justifying treatment of those infections in syndromic approaches.

The CDS initiated a comprehensive STD control programme. Gradually, 40 doctors were trained and guidelines for improved STD care at the primary care level were distributed to all care providers. Because the doctors often lack sufficient time, nurse-

counsellors were trained to provide counselling/education of cases and sexual contacts, and to promote safer behaviour and condom use. Systematic prenatal syphilis screening was reinstitutionalized. Materials such as posters, brochures, and picture-stories were developed for community-based education activities. A one-year supply of drugs for adequate treatment of common STDs was provided by WHO/PAHO at no cost. Patients paid modest sums for drugs, enabling the institution to replenish stocks. The CDS STD control programme director participated in a training session of STD programme managers in London.

In collaboration with PAHO/WHO, and with AIDSCAP and PAHO/WHO funding, the Cornell–GHESKIO centre provided STD case management training workshops for health care providers working throughout the island. A total of 116 doctors, 130 nurses, and 5 laboratory technicians were trained by the end of the project.

### **In 1994**

A coalition of 10 NGOs working in the Central Plateau started a comprehensive STD control programme comparable to the CDS activities. The technical director of this programme received supplemental training in the USA and developed institutional algorithms for STD case management. A one-year drug supply was provided at no cost by WHO/PAHO. Most NGOs instituted a cost-sharing system. Educational STD and HIV/AIDS messages were communicated via a local radio station.

### **In 1995**

One physician and one laboratory technician from the local STD centre of excellence received two weeks of training at the University of North Carolina. The quality of STD case management provided at the primary health care clinics was evaluated in the participating NGOs using the WHO/GPA questionnaire. Nine (69%) of 13 CDS doctors evaluated in the north-east of Haiti reported prescribing effective drug treatments for urethral discharge, compared to less than 10% in 1992. A total of 9 (56%) of 16 Central-Plateau-based doctors who were evaluated reported prescribing effective treatments for urethral discharge, while 5 (31%) reported treatment effective for gonorrhoea without treating for chlamydial infection. While syndromic STD care had been promoted by the institutions, some doctors continued to rely on case management by etiology. For example vaginal smear microscopy was often performed for the diagnosis of gonococcal infections. Some clinicians still interpreted the presence of

<sup>c</sup> Desormeaux J et al. Knowledge, perceptions, and attitudes regarding STDs among pregnant women and their partners living in a poor urban community in Haiti. Paper presented at: *Eleventh Meeting of the International Society for STD Research, 1995, New Orleans*. Abstract No. 169.

extracellular Gram-negative diplococci as evidence of infection. Except for one centre in the Central Plateau, the centres provided drugs for common STD syndromes at modest fees. Partner referral was best documented in the CDS centres since records were kept by the nurse-counsellors who also promoted condom use. As STD awareness and case management improved, community- and clinic-based education activities were intensified to improve care-seeking behaviour. For example, the CDS developed educational brochures for community health workers, a newsletter for physicians and nurses, educational posters, leaflets, and picture-stories targeting youth.

A first seminar was held with more than 70 care providers and decision-makers from different private and public organizations to review management of non-ulcerative genital infections in women. At the seminar, consensus was reached to strive towards standardized syndromic STD case management approaches and to develop national guidelines.

Representatives of the Ministry of Health, the local PAHO/WHO office, Cornell-GHESKIO, CDS, the Central Plateau NGO coalition, the University of North Carolina, and AIDSCAP formed a working group to develop national guidelines for STD case management. At a second seminar, also in direct collaboration with the Haitian Ministry of Health, participants reviewed management of genital ulcer disease and presented and discussed the national algorithms for syndromic approaches. Clinical case scenarios were used to test the use of the algorithms. Formatting and printing of the guidelines began.

A local NGO working with hard-to-reach female commercial sex workers started to plan collaboration with clinics and clinicians working in areas with high prevalence of prostitution to improve STD case management at the primary care level.

## Discussion

Despite the difficult political context in Haiti from 1992 to 1995, many of the socioeconomic and structural problems found there apply also to other resource-poor settings. The STD control challenges in Haiti are certainly not unique. Most developing countries lack a control programme and notification system for STDs and health-care-seeking behaviour and case management are usually problematic (4). Therefore, our experience may be relevant for other countries and programmes.

STDs are stigmatized in Haiti and, unlike the situation in neighbouring Jamaica (5), patients do

not present at specialized STD clinics for care. STD case management needed to be improved at the "points of first encounter" or primary health care clinics, which is more complicated than in a vertical care setting. Based upon our field experience, we believe that the five CDS primary health care centres at which suboptimal STD case management practices were observed at the beginning of the project may be considered representative of most STD care in Haiti in 1992. The evaluations in the north-eastern CDS and in the Central Plateau PHC centres showed that STD case management improved significantly. Counselling and education of STD patients, as well as partner referral and treatment, also improved in the participating health centres. Nevertheless, there is room for further amelioration. The STD patients seen at these clinics were predominantly female. Educational campaigns should be intensified to stimulate case-seeking by both women and men, with providers trained in adequate STD case management and away from self-treatment or other inadequate forms of care. Educational campaigns should also continue to promote partner treatment and compliance with therapy.

Because of a relatively high turnover of personnel in some clinics, the newly hired doctors had not yet learned the appropriate approach to STD care. Updating the training programme of the local medical school on STD case management should be a priority. Our experience convinced us that continued provider education and field supervision are critical. The syndromic approach has been recommended as the most realistic and cost-effective way to treat STDs in developing countries (6-9). However, doctors trained to request laboratory analyses for the diagnosis of infectious diseases were sometimes reluctant to give up habitual practices. We noticed that repeated messages were usually necessary to explain the rationale for syndromic STD care which is based upon treatment of the most prevalent STDs associated with a particular syndrome, as opposed to treatment based upon incomplete and frequently unreliable laboratory diagnosis.

The consensus reached for standardized STD case management across the different local institutions was arguably the greatest success achieved in this programme. We attribute this accomplishment to a combination of factors. First, since the onset of the AIDSCAP activities, deliberate efforts were made to involve all individuals interested in STD control in Haiti. We believe that the consensus would not have been reached without this collaboration. Second, the generation of local data was critical for consensus-building. For example, the data showing that chlamydial infections were more prevalent than gonococcal infections among the pregnant

women evaluated in Cité Soleil convinced local collaborators that males with urethritis and females with cervical infection should be treated for both chlamydial and gonococcal infections at the same time. Third, the presentation at international scientific meetings and the publication in a peer-reviewed biomedical journal of the baseline study results helped to convince local participants that the findings were credible. Fourth, local capacity-building through overseas training and on-site technical assistance also played an important role as it promoted insight into some technical/scientific aspects and, for example, helped to identify limitations or problems in the laboratory diagnosis of specific STDs. This international collaboration further promoted the acceptance of a public health approach to STD control using syndromic case management and appropriate simple laboratory technology. Fifth, strong Haitian partners and institutions committed to moving the policy agenda were essential. Sixth, the partnership between the U.S.-based and Haitian collaborators fostered a favourable climate. External support was used as needed. Finally, technical collaboration and funding as well as continuity among the key players were sustained over a 3-year period. We believe that this sustained commitment was also a key factor in reaching the consensus.

It is interesting to note that while most national STD guidelines are developed at the Ministry of Health, in Haiti they were developed during the first stage at the individual institutional levels, and in the second stage by several institutions and individuals in collaboration with the Ministry of Health, a bottom-to-top approach.

In conclusion, despite major constraints and the absence of a national STD control programme, it was possible to develop meaningful STD control activities in Haiti. The success of a control programme is evidenced when a reduction of the STD prevalence can be demonstrated or when the impact of improved syndrome-based STD case management on decreasing the HIV incidence can be shown (10). We have described a series of initiatives that were started in a chaotic context and, without asserting to demonstrate their outcome on the STD and HIV problem in Haiti, we can claim that the interventions laid the foundations for a national STD control strategy. A coherent national STD control programme should be implemented as soon as possible in both the public and private sectors. The programme will have to be multifaceted and include further research to address STD-care-seeking behaviour such as self-treatment and use of traditional healers. External funding will remain critical for STD control activities in Haiti owing to severely restricted resources at the national, organizational, and individual levels.

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## Résumé

### Approches de la lutte contre les maladies sexuellement transmissibles en Haïti de 1992 à 1995

Des activités de lutte contre les maladies sexuellement transmissibles (MST) ont été engagées en Haïti en 1992 en collaboration avec des organisations non gouvernementales locales, par le biais du Projet AIDSCAP de prévention et de lutte en matière de SIDA. Les principaux obstacles étaient d'une part l'impossibilité de collaborer avec le gouvernement et d'autre part une situation sociale et économique perturbée. Les approches de la lutte contre les MST comprennent l'examen des données locales disponibles, l'évaluation des pratiques et des difficultés en matière de prise en charge des cas, et l'élaboration d'activités spécifiques de lutte au niveau des soins de santé primaires, telles que le dépistage systématique de la syphilis chez les femmes enceintes et l'amélioration de la prise en charge globale des MST d'après les syndromes observés. Des études locales ont en outre été réalisées en vue de l'obtention de données de référence, lesquelles ont été communiquées aux principaux acteurs de la lutte; des prestataires de soins de santé ont été formés, les capacités locales ont été renforcées, et un consensus a été établi sur la mise en œuvre des approches de la lutte contre les MST.

Les connaissances concernant les MST se sont considérablement améliorées, de même que la prise en charge des cas. Par exemple, 69% des médecins interrogés ont fait état d'un traitement correct des MST dans les centres de soins de santé primaires du nord-est de l'île en 1995, contre moins de 10% en 1992. Alors qu'au début du projet différentes versions de l'algorithme de prise en charge des cas de MST selon l'approche syndromique avaient été élaborées par les divers établissements, à la fin du projet un consensus avait été établi entre les organisations

collaboratrices et le ministère de la Santé, et des directives nationales en matière de prise en charge des cas de MST avaient été développées. Il a donc été possible de mener des activités valables de lutte contre les MST dans un contexte très difficile. Parmi les leçons du projet figurent l'importance de l'obtention de données locales, de la communication et de la collaboration avec divers organismes en vue de l'établissement d'un consensus, la nécessité de la formation permanente, et la nécessité d'une supervision sur le terrain pour assurer que les prestataires de soins en matière de MST modifient leur approche. Un programme national de lutte contre les MST sera mis en œuvre dès que possible à la fois dans le secteur public et dans le secteur privé. Un financement extérieur restera indispensable pour lutter contre cet important problème de santé publique en Haïti.

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